Data Dictionary

Introduction

This section of the manual describes the data elements required to calculate category assignments and measurements for the core measures. It includes information necessary for defining and formatting the data elements, as well as the allowable values for each data element. This information is intended to assist the performance measurement system in processing patient level data elements for core measures.

It is of primary importance that all health care organizations using core measures gather and utilize the data elements as defined in this section, regardless of which performance measurement system is used. This will ensure that the data are standardized and comparable across organizations.

Regardless of which measure sets are selected by a health care organization, certain general data elements must be collected by the health care organization and submitted for **every** patient that falls into **any** of the selected measure set populations. These data elements are considered "general" to each patient's episode of care.

These data elements include:

- *Admission Date*
- *Admission Source*
- *Admission Type*
- *Birthdate*
- *Case Identifier**
- *Discharge Date*
- *Discharge Status*
- *Health Care Organization Identifier*
- *ICD-9-CM Other Diagnosis Codes*
- *ICD-9-CM Other Procedure Codes*
- *ICD-9-CM Other Procedure Dates*
- *ICD-9-CM Principal Diagnosis Code*
- *ICD-9-CM Principal Procedure Code*
- *ICD-9-CM Principal Procedure Date*
- *Other Patient Case Identifier***
- *Provider ID*
- *Patient HIC #***
- *Patient Social Security Number***
- *Payment Source*
- *Performance Measure Identifier*

- *Postal Code*
- *Sex*

* Case Identifier is required for all episodes of care collected for the Joint Commission.

** These patient identifiers are required to uniquely identify an episode of care for the National Voluntary Hospital Reporting Initiative. See individual data element pages for details.

Data Integrity

Editing Zero Values
Verification mechanisms are necessary to assure that zero is the intended data value rather than an initialization value for those data elements which have an allowable value of zero (i.e., 0.0, 0000, 0).

Editing 'Date' and 'Time' Data Elements
Performing simple edits between 'date' and 'time' data elements will help ensure data integrity.

Missing and Invalid Data
While there is an expectation that all defined data elements will be collected, the Joint Commission recognizes that in certain situations information may not be available (e.g., dates, times, codes, etc.). After due diligence, if the health care organization determines that a value is not documented, the organization should leave the data element blank. Please note that this should not be an issue for most data elements, since the allowable value "No" often incorporates the absence of documentation into the definition (only a handful of data elements include a specific "Not Documented" allowable value, such as Adult Smoking History ~~and Pneumococcal Vaccination Status Documented~~). For additional details on the proper handling of missing and/or invalid data, please refer to the Data Quality and the Missing and Invalid Data sections of this manual.

Interpreting Data Element Definitions and Allowable Values
Every attempt has been made to comprehensively define the core measure data elements and allowable values in a manner that obviates the need for interpretation. If, after reviewing the data element definition, including the notes and guidelines for abstraction, an abstractor cannot clearly assign an allowable value, the abstractor should contact his/her selected measurement system to request clarification. Measurement systems should contact the Joint Commission's *oryxcore@jcaho.org* mailbox, if they are unable to resolve the issue. Individual data abstractors should NOT interpret data element definitions or allowable values beyond the content of the data dictionary. For example, if an abstractor believes that a particular condition *should be* a contraindication for prescribing aspirin at discharge, but that condition is not included in the *Contraindication to Aspirin at Discharge* data element definition, it is NOT acceptable to "re-interpret" the existing definition. In this situation, the abstractor should contact his/her measurement

system to discuss the issue. The measurement system will pursue clarification with the Joint Commission, if necessary. Modifications to data elements will only be made through official updates of the specifications manual.

Interpretation of Data Dictionary Terms

Data elements fall into three broad categories in order to support a specific measure set. They include:

- *General Data Elements* – data elements that must be collected by health care organizations for each patient record:
  - data elements required for each episode of care (EOC) record submitted;
  - data elements used to identify the health care organization on each patient record, required for each patient-level record submitted; and
  - patient demographic data required for each episode of care record submitted and used for risk adjustment analysis (where applicable).

- *Measure-Specific Data Elements* – data elements used by one specific measure or several measures in one specific measure set, such as the heart failure measures.

- *Algorithm Output Data Elements* – data elements that must be calculated by the performance measurement system and are used to identify the results of processing a patient record through a measure algorithm (e.g., category assignment or measurement).

Data Element Dictionary Terms

Data Element Name: A short phrase identifying the data element.

Collected For: Identifies the measure(s) that utilize this data element or specifies that the data element is used for data transmission or verification.

Definition: A detailed explanation of the data element. *A measurement system may include this information in data collection software.*

Format:
Length =	number of characters or digits allowed for the data element	
Type =	type of information the data element contains (i.e., numeric, alphanumeric, date, decimal, or time)	
Occurs =	the number of times the data element occurs in a single episode of care record	

Allowable Values: A list of acceptable responses for this data element.

Notes for Abstraction: Provided to assist abstractor in the selection of appropriate value for a data element.

Suggested Data Source(s): Source document from which data can be identified such as administrative or medical record.

Guidelines for Abstraction: Designed to assist abstractors in determining how a data element should be answered.

> **Inclusions:**
> Inclusions are "acceptable terms" for particular data elements which should be abstracted as *positive findings* (e.g., "yes").
> Inclusion lists are limited to those terms which are believed to be most commonly used in medical record documentation**. The list of inclusions should not be considered all-inclusive.**
>
> In cases where Inclusion lists are lengthy, inclusion terms are outlined in an "inclusion table" format.

Exclusions:
Exclusions are "unacceptable terms" for particular data elements which should be abstracted as *negative findings* (e.g., "no"). Exclusion lists are limited to those terms an abstractor might question whether or not to abstract the term as a positive finding (e.g., "cardiomyopathy" is an unacceptable term for heart failure and should be abstracted as "no".). **The list of exclusions should not be considered all-inclusive.**

When both an inclusion and exclusion are documented in a medical record, the inclusion takes precedence over the exclusion, unless otherwise specified in the abstraction instructions. The abstractor would, therefore, abstract the inclusion as a positive finding (e.g., answer "yes"), unless otherwise specified in the instructions.